# CHAPTER IV. INDIVIDUAL HOSPITAL INPATIENT TABLES

### Facilities that Reported Data

BHI collected data from 130 general medical-surgical hospitals, 11 psychiatric hospitals, 1 alcohol and other drug abuse hospital, 2 rehabilitation facilities, and 2 state-operated mental health institutes on all inpatients discharged between January 1, 2002, and December 31, 2002. The database includes partial-year data from hospitals that opened or closed during the calendar year.

### Openings

LIFECARE Hospital of Milwaukee – Central Campus, First Quarter, 2002

Select Specialty Hospital – Milwaukee St. Luke's Campus, Fourth Quarter, 2002

Oak Leaf Surgical Hospital, Eau Claire, November, 2001 (no 2001 discharges)

### Special Circumstances

Due to common ownership and management, each of the following pairs of GMS hospitals was treated as a single facility for purposes of this report:

Saint Mary's Hospital (Rhinelander) and Sacred Heart Hospital (Tomahawk)

St. Luke's Medical Center-South Shore, Cudahy, and St. Luke's Medical Center, Milwaukee

Valley View Medical Center (Plymouth), and Sheboygan Memorial Medical Center

## How to Read the Tables

### GMS Hospital Tables

Each individual GMS hospital table contains the following two pages of information:

***First Page***

*Heading:* The heading identifies basic facility information. This includes the hospital's name, address, and telephone number; the hospital type (in this case, GMS); the county in which the hospital is located; and the analysis area and inpatient volume group to which it is assigned by BHI.

*Middle Section:* The middle section contains utilization data. This is divided into the following five subsections: Overall Hospital Utilization, Obstetrical Utilization, Psychiatric/ AODA Utilization, Patient Discharge Status, and Expected Pay Source Distribution.

*Overall Hospital Utilization:* These data provide an overall picture of utilization and charges at the facility. Included are total discharges, total patient days, average length of stay, and average charge per discharge for the calendar year. These items describe the number of inpatients discharged by a facility, the total number of days those patients stayed at the hospital, the number of days an average patient stayed, and the average charge billed for patients at the facility.

*Obstetrical Utilization:* The obstetric data identify the number of mothers that gave birth at the hospital (Total Deliveries) and the percentage of those deliveries that were "normal," that required C-sections, or that had complications or involved additional procedures (e.g., sterilization).

Below that, in the category "Total Births," appears the number of live births reported by the hospital during the calendar year. The number of deliveries and births may differ because some babies may have died during delivery, and some mothers may have given birth to twins, triplets, etc.

*Psychiatric/AODA Utilization:* These sections list the number of discharges and patient days attributed to those patients undergoing treatment for psychiatric disorders or alcohol and other drug abuse (AODA).

The table also lists the percentage of the hospital's total discharges and patient days that were generated by patients in either

psychiatric or AODA inpatient care. For example, if a hospital reported 10 patients discharged from psychiatric care and the hospital had 1,000 total discharges, then 1.0 percent of the hospital's discharges would be attributed to patients receiving psychiatric inpatient services.

*Patient Discharge Status Distribution:* This section describes where patients went after being discharged from the hospital. It lists the percentage of patients who went home, were transferred to another GMS hospital, were sent to a nursing home (skilled nursing or intermediate care facility), were sent to an inpatient rehabilitation facility, were discharged to a hospice, were sent to another type of institution (e.g., a half-way house or residential facility), were referred to a home health agency, left the hospital against medical advice, expired (i.e., died), or were discharged to some other type of care (which includes referral to a home health agency for intravenous drug therapy, transfer within the institution to a hospital-based Medicare swing bed, transfer to a Medicare-certified long-term hospital, transfer to a nursing facility certified under Medicaid but not certified under Medicare, or transfer to the same or another facility for outpatient services as specified by the discharge plan of care).

*Note: This section has been changed from previous years to reflect the addition of new discharge status codes.*

*Expected Pay Source Distribution:* This section lists the primary payer who is expected to reimburse the hospital for services. The payer categories are Medicare, Medical Assistance, other government (e.g., county general relief, 51.42 Boards), commercial insurance, self-pay, and unknown. The category "Commercial Insurance" includes traditional and self-funded plans, private alternate payment systems (e.g., HMOs, PPOs), and Workers' Compensation.

***Note**: Primary payer data reflects the party billed for the service at the time of patient discharge. The actual payer may differ if the facility cannot collect from an expected payer or a third-party payer later finds a patient to be ineligible for coverage. Summary data on actual payers can be found in the BHI **Guide to Wisconsin Hospitals**, published annually.*

*Bottom Section:* This section describes patient characteristics including age, sex, and race.

*Age Distribution:* This section presents the percentage of total discharges and patient days reported for various age groups.

*Sex Distribution:* This section presents the percentage of total discharges and patient days reported for males and females.

*Race Distribution:* This section presents the percentage of total discharges and patient days reported for various racial groups. The groups are based on Census categories and include Native Americans, Asian/Pacific Islanders, Blacks, Whites, Other, and Unknown. Patients voluntarily provided race information. Because BHI relies on the cooperation of patients for collection of this data, its reliability varies from facility to facility.

***Second Page***

The second page of each GMS hospital table presents utilization and charge data for selected DRGs. Data are presented for the individual hospital and for three comparison groups. The comparison groups include all GMS hospitals in the same analysis area, all hospitals in the same inpatient volume group, and all GMS hospitals statewide. (See the Reader's Guide on page 5 for explanations of analysis areas and inpatient volume groups.)

DRGs were selected by choosing the 15 most common DRGs at hospitals in each of the inpatient volume groups. Therefore, the DRGs used to compare hospitals in one inpatient volume group may differ from those used to compare hospitals in another inpatient volume group.

*Average Length of Stay (ALOS):* This section lists the number of discharges and the average

length of stay at the facility for each of the 15 selected DRGs. The facility averages are then compared to the average length of stay at the three comparison groups, and a ratio of that comparison is computed.

If the facility reported a length of stay for a given DRG that was greater than the average reported by hospitals in a comparison group, the ratio would be greater than 1.00; if it was equal, the ratio would be 1.00; if it was less at the hospital than in the comparison groups the ratio would be less than 1.00.

*Example:* If the average length of stay for DRG 373 at Hospital A was 2.1 days and the analysis area average was 2.0, the ratio in the analysis area column would be 1.05. This means that the average length of stay at Hospital A was 5 percent longer than the average stay for the analysis area.

*Average Charge:* This section displays actual and risk-adjusted average charge data for the selected DRGs. Actual average charges are presented for the hospital. Risk-adjusted average charges are shown for the hospital and for the comparison groups. Risk-adjusted average charges were calculated by removing the effect of severity variation from each patient's charges and averaging the results for the hospital and comparison groups. (See the Technical Note in Appendix 3 for an explanation of how the data were risk-adjusted.)

The hospital's risk-adjusted average charges may be compared to the risk-adjusted average charges of the comparison groups. While risk-adjustment attempts to remove severity differences, other "unadjusted" factors may influence variation. To date, risk-adjustments have not been developed which can account for social or cultural differences affecting health care utilization.

The table lists the risk-adjusted charge for each of the comparison groups (analysis area, inpatient volume group, and all GMS hospitals) and calculates the ratio of the hospital's risk-adjusted average charge for a DRG to that of the comparison group. These ratios are calculated and may be interpreted in the same manner as the ratios for average length of stay.

No ratios are calculated for a DRG when a hospital had fewer than five discharges assigned to that DRG.

## Specialty Hospital Tables

The tables for the psychiatric and AODA hospitals and the state-operated mental health institutes are one page long. They include much of the same descriptive data as the GMS tables, including data on DRGs, but exclude risk-adjusted data, inpatient volume group, and analysis area comparisons. The format for the rehabilitation hospital tables differs substantially from the tables for the other specialty hospitals and is described later in this section.

*Heading*: The top of the page contains the same information as the heading on a GMS table, except that no volume group is listed since all specialty hospitals have been assigned to inpatient volume group 7.

*Middle Section*: The middle section contains the utilization and patient characteristic data contained in the middle and bottom sections of the first page of the GMS tables, except obstetrical utilization. It is divided into the following seven subsections: Overall Hospital Utilization, Psychiatric/AODA Utilization, Patient Discharge Status, Expected Pay Source Distribution, Age Distribution, Sex Distribution, and Race Distribution.

The age groups for specialty hospitals differ from those used for GMS hospitals. (GMS hospital tables have an age category "15-44" years of age; specialty hospital tables divide this into "15-19" and "20-44" to emphasize the presence of adolescent treatment programs in specialty hospitals.)

*Bottom Section, for Psychiatric and AODA Hospitals*: This section of the table includes data on all psychiatric and AODA DRGs (DRGs 424

through 433 and 521-523). Facility-specific data are compared to statewide psychiatric and AODA data for patients treated in psychiatric, AODA, and GMS facilities.

The first column lists the DRG number and its description. The table then lists the number of discharges at the hospital for that DRG.

In the columns under the broader heading "Average Length of Stay (ALOS)," the hospital's average length of stay for the DRG is compared to that of patients assigned to the same DRG in GMS, psychiatric, and AODA hospitals statewide, and a ratio of that comparison is computed. These ratios are calculated and may be interpreted in the same manner as the ratios for average length of stay at GMS hospitals.

In the columns under the broader heading "Average Charge per Discharge," the hospital's average charge for patients assigned to a DRG is compared to the average charge for all patients assigned to that DRG statewide (excluding those treated at the state mental health institutes). As with length of stay, a ratio computed from this comparison is also provided.

Psychiatric and AODA charge data were not risk-adjusted because differences in charges among psychiatric and AODA patients typically reflect programmatic differences, rather than differences in severity of illness.

*Bottom Section, for the State-Operated Mental Health Institutes*: The table identifies and describes the DRGs and presents the number of discharges, ALOS, and average charge per discharge for patients in those DRGs. Since patients at the state-operated mental health institutes are unique in terms of illness severity, charges, and length of stay, no comparisons are made to other groups and no ratios are calculated. Average charge and ALOS data are not risk-adjusted.

## Rehabilitation Hospital Tables

Rehabilitation hospitals are dedicated solely to rehabilitation medicine and treat a unique class of patients. Because the federal government has not yet developed diagnosis-related groups for rehabilitation conditions, these facilities are exempt from DRG reimbursement requirements imposed on other hospitals. In addition, the rehabilitation hospitals report data differently from other hospitals that have rehabilitation units. For these reasons, DRG-based comparisons of rehabilitation hospitals with other hospitals are not valid. Although comparisons are not currently possible, this report provides a summary of the rehabilitation hospitals' utilization and charge data. When rehabilitation services fall under DRG reimbursement, comparisons with other facilities will be possible.

*Heading:* The heading lists the hospital's name, address, and telephone number, and identifies the hospital type and the county and analysis area in which it is located.

*Body of the Table*: The body of the table contains utilization and patient characteristic data, divided into the following six subsections: Overall Hospital Utilization, Age Distribution (age groups are the same as for other specialty hospitals), Selected Patient Groups, Expected Pay Source Distribution, Sex Distribution, and Race Distribution. These categories are the same as on the other tables, except Selected Patient Groups.

*Selected Patient Groups:* Since DRGs are not applicable to rehabilitation hospital patients, BHI presents utilization and charge data using the rehabilitation diagnostic categories of the federal Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration). This methodology aggregates patients into broad categories, such as stroke and hip fracture. The rehabilitation hospital tables list the following categories:

Stroke
Brain Injury or Damage
Arthritis
Other Neurological Disorders
Hip Fracture
Miscellaneous Rehabilitation

***Note**: The table in Appendix 3 shows the ICD-9-CM codes for the categories used in the rehabilitation hospital tables. The "miscellaneous rehabilitation" category is composed of specific diagnostic codes not found in the other ten categories.*

The table lists the patient group (e.g., stroke, brain injury or damage), and the number of discharges, average charge, and average length of stay for each category.

***Note:** Average charge and average length of stay data are not risk-adjusted.*

## *Description of DRGs Used in the Report*

BHI used Federal fiscal year 2002 DRG Grouper computer software, based on the 506 DRG classifications defined by the federal Department of Health and Human Services, to assign each hospitalization to a DRG. The following DRGs appear in the report (CC stands for complications or comorbidities):

***DRG 014*** - *Specific Cerebrovascular Disorders except Transient Ischemic Attack (commonly referred to as stroke):* includes cerebral embolism, subdural hemorrhage, intracerebral hemorrhage, intracranial hemorrhage, cerebral artery occlusions, and cerebral thrombosis.

***DRG 088*** - *Chronic Obstructive Pulmonary Disease:* includes chronic bronchitis, emphysema, chronic obstructive asthma, and congenital bronchiectasis.

***DRG 089*** - *Adult Pneumonia and Pleurisy with CC:* includes bacterial pneumonia, viral pneumonia, pleurisy without effusion or tuberculosis, and bronchopneumonia.

***DRG 091*** - *Simple Pneumonia and Pleurisy, Age 0-17:* includes bacterial pneumonia, viral pneumonia, pleurisy without effusion or tuberculosis, and bronchopneumonia.

***DRG 098*** – *Bronchitis and Asthma, Age 0 - 17:* includes whooping cough, acute bronchitis, intrinsic and extrinsic asthma, and acute tracheitis.

***DRG 103*** - *Heart Transplant:* includes all heart transplantations.

***DRG 104*** - *Cardiac Valve Procedures and Other Major Cardiothoracic Procedures with Cardiac Catheterization:* includes open valvuloplasty, valve replacement, and implantation or replacement of heart-assist system in conjunction with left, right, or combined cardiac catheterization or coronary arterioriogram, angiocardiogram, or cardiogram.

***DRG 105*** - *Cardiac Valve Procedures and Other Major Cardiothoracic Procedures without Cardiac Catheterization:* includes open valvuloplasty, valve replacement, and implantation or replacement of heart-assist system without cardiac catheterization.

***DRG 106*** - *Coronary Bypass with PTCA (Percutaneous Transluminal Coronary Angioplasty):* includes aortocoronary bypass graft of one or more coronary arteries in conjunction with percutaneous valvuloplasty or coronary atherectomy, PTCA.

***DRG 107*** - *Coronary Bypass with Cardiac Catheterization:* includes aortocoronary bypass graft of one or more coronary arteries with cardiac catheterization, angiocardiogram, coronary arteriogram, or cardiogram.

***DRG 108*** - *Other Cardiothoracic Procedures:* includes atrial or ventricular septa repair, total repair of certain congenital cardiac anomolies, heart aneurysm excision, excision of heart lesion, heart incision, and revascularization.

***DRG 109*** - *Coronary Bypass without Cardiac Catheterization:* includes aortocoronary bypass graft of one or more coronary arteries.

***DRG 115*** - *Permanent Cardiac Pacemaker Implant with Acute Myocardial Infarction (AMI), Heart Failure or Shock or AICD Lead or General Procedure:* includes insertion of original or replacement pacemaker in patients who had heart attack, heart failure, or shock.

***DRG 116*** - *Other Cardiac Pacemaker Implantation: :* includes insertion of original or replacement pacemaker in patients with conduction disorders, cardiac dysrhythmias, chronic ischemic or pulmonary heart disease, and cardiomyopothy.

***DRG 117*** - *Cardiac Pacemaker Revision Except Device Replacement:* includes revision or removal of pacemaker or insertion, replacement, or revision of pacemaker lead wires.

***DRG 118*** - *Cardiac Pacemaker Device Replacement:* includes replacement of cardiac pacemaker device for one or more cardiac chambers.

***DRG 125*** *- Circulatory Disorders Except Acute Myocardial Infarction with Cardiac Catheterization without Complex Diagnosis:* includes heart disease, chest pain, cardiac dysrhythmia and hypertension, with cardiac catheterization, angiocardiogram, arteriogram or cardiogram.

***DRG 127*** *- Heart Failure and Shock:* includes heart failure, hypertensive heart disease with congestive heart failure, and congestive heart failure with inactive rheumatic fever.

***DRG 138*** *– Cardiac Arrhythmia and Conduction Disorders with CC:* includes atrial or ventricular fibrillation and flutter, cardiac dysrhythmia, tachycardia, conduction disorders, and complications with mechanical cardiac defibrillators and pacemakers, with CC.

***DRG 139*** *- Cardiac Arrhythmia and Conduction Disorders without CC:* includes any principal diagnosis under DRG 138, without CC.

***DRG 140*** *- Angina Pectoris:* severe, squeezing or pressure-like thoracic pain, brought on by some form of exertion or stress; includes angina decubitis, prinzmetal angina, intermediate coronary syndrome, and coronary occlusion without myocardial infarction.

***DRG 143*** *- Chest Pain:* includes chest pain and precordial pain, usually related to coronary conditions.

***DRG 148*** *- Major Small and Large Bowel Procedures with CC:* includes excision of small or large intestine, colectomy, colostomy, ileostomy, and repair of fistula.

***DRG 174*** *- Gastrointestinal Hemorrhage with CC:* includes acute and chronic stomach, duodenal, peptic, or marginal ulcer; gastritis; duodenitis; diverticulosis of small intestine or colon; and rectal or anal hemorrhage.

***DRG 182*** *- Adult Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders with CC:* includes gastroenteritis and colitis, diverticulosis without hemorrhage, abdominal pain and swelling, food poisoning, intestinal infection, salmonella, esophagitis, and other digestive tract disorders with CC.

***DRG 183*** *- Adult Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders without CC:* includes any principal diagnosis listed under DRG 182, without CC.

***DRG 209*** *- Major Joint and Limb Reattachment Procedures of the Lower Extremities:* includes total and partial hip replacement, total knee replacement, revision of hip or knee replacement, ankle replacement, and leg reattachment procedures.

***DRG 210*** *- Adult Hip and Femur Procedures except Major Joint, with CC:* includes open and closed reduction of femoral and hip fractures, bone grafts, partial and total ostectomy, and femur length change.

***DRG 211*** *– Adult Hip and Femur Procedures except Major Joint without CC:* includes open and closed reduction of femoral and hip fractures, bone grafts, partial and total ostectomy, and femur length change.

***DRG 212*** *- Hip and Femur Procedures except Major Joint, Age 0 through 17:* includes pediatric bone grafts, open and closed reduction of femoral and hip fractures, partial and total ostectomy, and femur length change.

***DRG 239*** *– Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy:* includes pathological and stress fractures, malignant neoplasms of bone and articular cartilage or connective and other soft tissue, and granulomatosis.

***DRG 243*** *- Medical Back Problems:* includes lumbago, disc displacement, disc disease, stenosis, congenital dysfunction, sciatica, backache, scoliosis, fractures and dislocations of vertebrae, or sprains.

***DRG 296*** *- Adult Nutritional and Miscellaneous Metabolic Disorders with CC:* includes dehydration; sodium, potassium or calcium deficiency or excess; other vitamin, mineral, or nutritional deficiency; hypoglycemia; abnormal weight loss or gain, and anorexia.

***DRG 298*** *– Nutritional and Miscellaneous Metabolic Disorders, Age 0-17:* includes any principal diagnosis under DRG 296.

***DRG 302*** *– Kidney Transplant:* includes kidney transplantation except renal autotransplantation.

***DRG 359*** *- Uterine and Adnexa Procedures for Non-Malignancy without CC:* includes abdominal and vaginal hysterectomy and other operations on the female genital organs, such as oophorotomy, salpingotomy, biopsy, and hysterotomy.

***DRG 370*** *- Cesarean Section with CCs:* delivery by surgery, commonly following, but not limited to, multiple birth, breech presentation, fetal distress, cord problems, threatened abortion, hemorrhage, early placenta previa, eclampsia, edema, genitourinary infection, sexually transmitted disease, or rubella.

***DRG 371*** *- Cesarean Section without CC:* delivery by surgery, commonly following, but not limited to, multiple birth, breech presentation, fetal distress, cord problems, threatened abortion, hemorrhage, early placenta previa, eclampsia, edema, genitourinary infection, sexually transmitted disease, and rubella.

***DRG 372*** *- Vaginal Delivery with Complicating Diagnoses:* includes all vaginal deliveries with accompanying complications.

***DRG 373*** *- Vaginal Delivery without Complicating Diagnoses:* includes all vaginal deliveries without accompanying complications.

***DRG 374*** *- Vaginal Delivery with Sterilization and/or D&C:* includes single and multiple delivery, cord prolapse, eclampsia, or breech and other malposition coupled with tubal ligation, removal of fallopian tubes, and/or post-delivery dilation and curettage.

***DRG 375*** *- Vaginal Delivery with Operating Room Procedure except Sterilization and/or D&C:* includes single and multiple delivery, cord prolapse, eclampsia, or breech and other malposition coupled with hemorrhage control, laparoscopy, treatment of cervical lesions, hysterectomy, uterine repair, and other operations on the female reproductive system.

***DRG 385*** *- Neonates, Died or Transferred to Another Acute Care Facility*

***DRG 386*** *- Extreme Prematurity or Respiratory Distress Syndrome of Neonate:* includes extreme prematurity or respiratory distress syndrome.

***DRG 387*** *- Prematurity with Major Problems:* includes premature infants with viral or bacterial infections, malnutrition, hypoglycemia electrolyte imbalance, respiratory distress, anemia, injury, hernia, and digestive system anomalies.

***DRG 388*** *- Prematurity without Major Problems:* includes premature infants without any major health problems beyond prematurity.

***DRG 389*** *- Full-Term Neonate with Major Problems:* includes full-term infants with respiratory distress, hypoglycemia, viral or bacterial infections, malnutrition, electrolyte imbalance, injury, hernia, and digestive system anomalies.

***DRG 390*** *- Neonate with Other Significant Problems:* includes all babies with major physical problems that are not assigned to any other DRG.

***DRG 391*** *- Normal Newborn:* includes all normal babies, including multiple births, forceps babies, unusually large infants, and breech babies.

***DRG 424*** *- Operating Room Procedure with Principal Diagnosis of Mental Illness:* includes any operating room procedure performed on a patient with a principal diagnosis of mental disease.

***DRG 425*** *- Acute Adjustment Reactions and Disturbances of Psychosocial Dysfunction:* includes acute delirium, panic disorders, hysteria, psychogenic disorders, factitious illnesses, stress reactions, and hallucinations.

***DRG 426*** - *Depressive Neuroses:* includes neurotic depression, chronic depression, brief depressive reaction, prolonged depressive reaction, and depressive disorder.

***DRG 427*** - *Neuroses except Depressive:* includes adjustment reactions, phobias, obsessive-compulsive disorders, hypochondriasis, neurotic disorders, anxiety, or prolonged post-trauma stress.

***DRG 428*** - *Disorders of Personality and Impulse Control:* includes intermittent explosive disorder, anorexia nervosa, borderline personality, multiple personality, paranoid personality, antisocial personality, explosive personality, narcissistic personality and compulsive personality.

***DRG 429*** - *Organic Disturbances and Mental Retardation:* includes senility (dementia, delirium, depression), organic brain syndrome, infantile autism, organic personality syndrome, mental retardation (mild, moderate, severe), Down's syndrome, or arteriosclerotic dementia.

***DRG 430*** - *Psychoses:* schizophrenia (simple, paranoid, latent, residual), depressive psychosis, catatonia, bipolar affective disorder (manic, depressed, mixed), paranoia, and psychosis not otherwise specified.

***DRG 431*** - *Childhood Mental Disorders:* includes attention deficit disorders, childhood and adolescent emotional disturbances, and impulse control and other social conduct disorders.

***DRG 432*** - *Other Mental Disorder Diagnoses:* includes eating disorders, sexual deviations and disorders, and sleeping disorders.

***DRG 433*** - *Alcohol/Drug Abuse or Dependency, Left Against Medical Advice:* patient diagnosed as having an alcohol, drug abuse, or chemical dependency condition, but left the hospital against medical advice.

***DRG 462*** - *Rehabilitation:* includes fitting of prosthesis; physical, occupational, or speech therapy; and other rehabilitation procedures.

***DRG 475*** – *Respiratory System Diagnosis with Ventilator Support:* includes continuous, mechanical ventilation and is a non-operating room procedure.

***DRG 480*** - *Liver Transplant:* includes all liver transplants.

***DRG 481*** - *Bone Marrow Transplant:* includes all bone marrow transplants.

***DRG 483*** - *Tracheostomy except for Face, Mouth, and Neck Diagnoses:* includes temporary and permanent tracheostomy (surgical formation of an opening into the trachea through the neck).

***DRG 495*** - *Lung Transplant:* includes all lung transplantations.

***DRG 497*** - *Spinal Fusion Except Cervical with CC:* includes anterior, posterior, and lateral spinal fusion and refusion.

***DRG 498*** - *Spinal Fusion Except Cervical without CC:* includes anterior, posterior, and lateral spinal fusion and refusion.

***DRG 499*** - *Back and Neck Procedures Except Spinal Fusion with CC:* includes excision of intervertebral disc, exploration and decompression of spinal canal, reopening of laminectomy site, and insertion or replacement of spinal neurostimulator.

***DRG 500*** - *Back and Neck Procedures Except Spinal Fusion without CC:* includes excision of intervertebral disc, exploration and decompression of spinal canal, reopening of laminectomy site, and insertion or replacement of spinal neurostimulator.

***DRG 504*** - *Extensive Third Degree Burn with Skin Graft:* includes burns involving 20% or more of body surface with 10% or more third degree with skin graft.

***DRG 506*** - *Full Thickness Burn with Skin Graft or Inhalation Injury with CC or Significant Trauma:* includes third-degree burns with skin graft or principal or secondary diagnosis of inhalation injury, including respiratory failure;

burns of larynx, trachea, and lung; or poisoning by gases, fumes, or vapors.

***DRG 517*** *– Percutaneous Cardiovascular Procedures without Acute Myocardial Infarction, with Coronary Artery Stent Implant:* includes coronary atherectomy, percutaneous transluminal coronary angioplasty, single or multiple vessel, with or without thrombolytic agent, and insertion of coronary artery stent(s).

***DRG 521*** *– Alcohol/Drug Abuse or Dependence with CC:* includes drug or alcohol psychosis, drug or alcohol dependence, acute alcoholic intoxication and alcoholism, and abuse of alcohol or a wide variety or drugs.

***DRG 522*** *– Alcohol/Drug Abuse or Dependence with Rehabilitation Therapy without CC:* includes any of the diagnoses in DRG 521 with rehabilitation therapy without CC.

***DRG 523 -*** *Alcohol/Drug Abuse or Dependence without Rehabilitation Therapy without CC:* includes any of the diagnoses in DRG 521 without rehabilitation therapy without CC.

## Caveats/Data Limitations for Hospital Inpatient Data

1. The charge data in this report are based on Uniform Patient Billing (UB-92) form information and have not been audited. **As a result, the charge data provided in this report may differ from audited financial data.**
2. The reported payment sources are *expected* sources of payment at the time of billing rather than actual revenue sources. Therefore, the reported distribution of payment sources in this report may differ from the actual distribution of final revenue sources.
3. The utilization and charge figures in the narrative portion of this report were not adjusted for disease severity or any of a variety of other factors that could affect hospital averages. However, risk-adjustment was performed on hospital-specific DRG charge data in the individual tables of GMS hospitals. In addition to differences in case mix and intensity of illness, regional pricing differentials and variations in services can affect utilization or charge figures. Also, differences in hospital patient record-keeping systems and internal information systems may affect the quality of the data submitted by individual hospitals.
4. BHI used standard grouper computer software to assign a hospitalization to a particular DRG based on up to nine diagnoses and six procedures and the sex, age, and discharge status of the patient. The grouping software can utilize more diagnoses and procedures than were collected by BHI. As a result, minor differences in the assigned DRGs can result if persons with access to the hospital's original billing forms use more diagnoses or procedures with their grouper than were submitted by the hospital to BHI.
5. The software used by BHI to assign DRGs is Medstat's Version 19 of the DRG GROUPER, effective October 1, 2001. This software used several new DRGs not found in previous versions of the grouper. This may affect comparisons of DRG utilization and charges over several years by assigning certain patients to DRGs that did not previously exist.
6. Care should be taken when comparing data from hospitals that reported small numbers of cases. A few unusual cases may unduly affect the average lengths of stay or charges for a given DRG with a small number of total cases.
7. Lengths of stay for inpatients who remained in the hospital less than 24 hours were counted as one day in this report. In other analyses these may be considered zero-day lengths of stay.
8. Calculations of average charge per discharge excluded any discharge with a stay longer than 100 days. Charges for stays greater than 100 days are excluded because hospitals are not required to report charge data for these patients, and reporting of these data is inconsistent among hospitals. An exception occurs at the two state-operated mental health institutes: charge data are included for all patients at these hospitals, except those whose length of stay was 1,000 days or greater (see caveat 9).
9. All hospitalizations of 1,000 days or longer were excluded from the data entirely. During 2002, 30 patients had lengths of stay 1,000 days or longer; 29 of these patients were hospitalized at the state-operated mental health institutes.